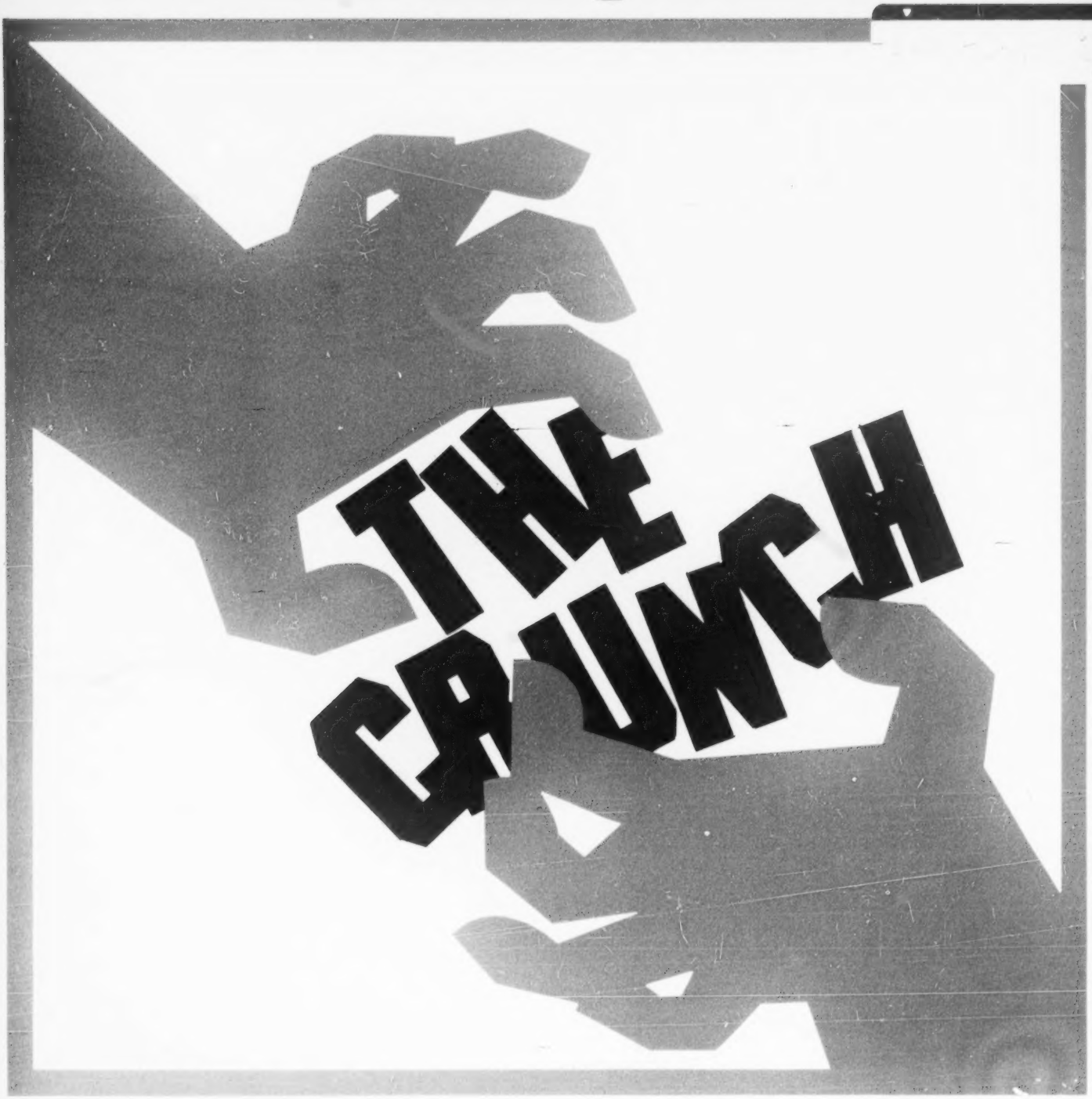

The health insurance crisis comes to america's charities

FAMILIES USA REPORT • FIVE DOLLARS

The Crunch

The Health Insurance Crisis Comes to America's Charities

A report by

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Introduction

Escalating health insurance costs are wreaking havoc with the budgets of America's charities and their employees. Not only are health insurance costs devouring charitable dollars directly, but the unaffordable cost of health insurance is forcing America's charities to waste scarce administrative resources on strategies to control premiums. Too often, high premiums and limited dollars are forcing these charities to pass health costs on to their employees, threatening the economic security of employees committed to carrying out the charitable missions of these organizations.

These conclusions are based on almost 500 responses to a Families USA survey last year. In order to better understand the health insurance experiences of small businesses offering insurance, and therefore the health reform needs of these businesses, Families USA Foundation surveyed over 2500 non-profit, charitable organizations. Families USA chose to survey non-profit charities because the Foundation itself had very troubling experiences with health insurance and had become increasingly concerned as health insurance costs consumed more and more of the charitable dollars donated to the Foundation. The Foundation hypothesized that many other small charitable organizations were having similarly troubling experiences and would benefit from reform.

The Foundation sought to identify networks of non-profit organizations that represented a variety of charitable services—services for children and for seniors; health care services; and services provided by religious organizations. The following associations of non-profit organizations participated with Families USA in the survey: the National Association of Area Agencies on Aging; the National Association of Church Personnel Administrators; the National Association of Community Health Centers; the National Headstart Association; and Independent Sector. Almost 500 surveys were returned. A copy of the survey instrument is attached as Appendix A. The survey findings are summarized below.

Non-profit charitable organizations are a subset of small businesses in this country. The majority of small businesses in the United States offer health insurance to their employees. As of 1986, the latest year for which such data are available, just under half (46%) of firms with 1-9 employees offered health insurance; over three-fourths (78%) of firms with 10-24 employees offered health insurance; and almost all (92%) of firms with 25-99 employees offered health insurance.[1]

In the debate over health reform, however, small business associations have frequently focused on the interests of the minority of small businesses that do not offer insurance, rather than on the interests of the majority that do offer insurance. The Chamber of Commerce and the National Federation of Independent Businesses, for

example, have adamantly opposed reforms that would require all employers to purchase or pay for health insurance and, at the same time, would establish effective cost containment measures that would restrain escalating health care costs. Such reforms obviously would increase costs for the minority of small businesses that do not currently offer health insurance benefits, but could result in significantly reduced future costs for the small businesses currently providing such benefits. This survey will hopefully contribute to a better understanding of the reform needs of the majority of small businesses that provide health insurance.

Key Findings from The Survey

▸ All (467) organizations responding offered health insurance for their employees. Eighty-seven percent offered health insurance for dependents. Firms with over 100 employees were the most likely to do so (97%), whereas firms with 15 or fewer employees were the least likely to offer family coverage (78%).

▸ Both managed care and indemnity plans experienced stiff premium increases over the last three years, from 1988 to 1991. Family managed care plans had the largest average increase (96%); family indemnity plans had the second largest growth rate (91%); and individual indemnity plans grew at the third most rapid rate (84%). Average annual premium increases exceeded 20 percent for virtually all plans and years studied.

▸ The median amount spent by charitable organizations on health insurance, as a percentage of payroll, increased from 6.6 percent in 1988 to 8.4 percent in 1991—an increase of 27 percent.

▸ Almost all charitable organizations (90%) have taken steps to lower health care costs. The most frequent step taken was the solicitation of bids from other insurers (82%). Close to half (49%) of the charities raised individuals' and families' out-of-pocket costs through one or more of the following methods: changing the type or number of services covered (34%); increasing deductibles for individuals (31%) and families (28%); increasing premium contributions for families (28%) and individuals (16%); and increasing the coinsurance percentage (10%).

▸ Over one-half of the respondents indicated that the rising costs of health care have constrained employee salaries. Roughly one-third indicated that these costs have hindered staff expansion for additional charitable services.

▸ Ten percent of the respondents had individuals excluded from coverage due to their health history.

▸ Over one-quarter of the respondents had policies that excluded coverage for pre-existing conditions.

▸ One quarter of the respondents were rejected by at least one insurer. Common reasons for such rejections were: exclusion of industry, health history and past claims experience.

▸ Coverage was typical of most group insurance plans, with the overwhelming majority of charities covering their employees' hospital care, surgical services, physician office visits, X-ray and laboratory services, and inpatient and outpatient mental health services. Over three-quarters of the respondents offered prescription drugs and three-fifths offered dental benefits.

Background—The Small Business Market

The health insurance experiences of the charitable organizations responding to the survey are typical of the problems with the small group health insurance market. As health costs have escalated at twice the rate of inflation over the last decade, small groups have found themselves more and more victimized by aggressive efforts of insurers to limit their risks. Many firms with 100 or more employees now self-insure and are not dependent on insurers. Smaller groups cannot spread the risk among themselves and are therefore dependent on private insurers.

Nationally, as a recent study by the National Federation of Independent Businesses (NFIB) documents, the cost of health insurance is the most critical problem faced by small businesses.[2] Both big and small firms suffer tremendously from the spiraling effects of health care costs. Small firms, however, are at a disadvantage purchasing health insurance. A 1987 Small Business Administration survey found that small businesses pay 10 to 40 percent higher premiums for comparable plans and benefits.[3]

"Rising premiums will create very real financial hardships for our office in the immediate future. Our last choice is to pass on premium cost burdens to our staff, who have already been denied a cost of living raise this year. Larger deductibles (doubled from last year) are a difficult problem especially for the lower end of the staff pay scale. This means that some people find health care difficult to afford even though we provide health insurance."—the administrator of a six-employee social action group in Washington, DC.

High Premiums for Small Groups

High Administrative Costs—Small groups pay a higher percentage of their premiums for insurers' administrative costs than do large groups. This happens for several reasons. First, some insurers' costs, such as marketing costs, are fixed and amount to a higher percentage of small group premiums than of large group premiums. Secondly, insurers generally must provide more services directly to small group members than to large groups that have benefit managers. Thirdly, small

groups' claims experiences are more difficult to predict, so insurers retain a higher proportion of premiums as reserves. Finally, insurers incur underwriting expenses for small groups and not for large groups.[4]

Ironically, one of the most common steps taken by small businesses to address these high administrative expenses is to switch insurance carriers. Unfortunately, switching carriers actually boosts the administrative expense component of small group insurance.

Restrictive Rating Practices—In addition to the higher administrative costs small groups must pay, they also pay more for insurance because of the aggressive experience-rating practices adopted by most insurers over the last decade. Previously, most insurers used community-rating—setting premiums based on the average health costs of an entire pool of customers in a geographic area. Over the last decade, insurers attempted to underbid each other by experience-rating—basing premiums on the actual or anticipated health care needs of a small group. As long as groups appear to be healthy, premiums are relatively lower. But premiums rise rapidly as health problems develop in one or more employees. Premiums are generally lower in the first year of an insurance contract because insurers initially tend to set premiums low to attract business and then raise them in subsequent years. In addition, premiums go up as coverage exclusions for pre-existing conditions expire. Finally, insurers assume that the longer a group remains with an insurer, the greater the likelihood that the group's health status will deteriorate and claims costs will increase. Insurers therefore raise premiums for groups renewing their coverage.

"In 1990, the premium for the same coverage as 1989 increased 91%, so less coverage was selected at a 30% increase. In 1991, the same company proposed a 150% increase for the same limited coverage we chose in 1990. We were forced to seek another company with great difficulty. We did not have excessive claims EVER."—nine-employee Florida human services group

The rise of experience-rating plans has brought with it the increased use of medical underwriting. Medical underwriting is the process by which an insurer evaluates the health history and the potential for poor health status of an individual or group and sets premiums accordingly. As a result of underwriting, insurers may exclude some individuals from coverage, or exclude coverage of pre-existing health conditions for a set period of time or totally. Not only does medical underwriting result in high premiums for businesses with sick employees, but the process also adds to total premium costs by boosting administrative expenses.

While restrictive rating practices have tremendous potential to raise health insurance costs, they also severely curtail the availability of health insurance for certain individuals and groups. For instance, redlining—the process by which insurers exclude entire industries—is applied to many different types of businesses. Non-profit charities are among those businesses redlined by some insurers. One reason is that insurers associate them with high administrative costs. Insurers also believe that non-profit charities are financially unstable and may cancel their coverage precipitously, denying insurers the opportunity to recoup any losses. Businesses in high risk occupations, such as mining or logging, often are denied coverage due to the high potential

Experience of a five-employee educational services group in North Carolina: *individuals were rejected for once having benign cysts; for having a Cesarean-section; and for once having gone for counseling.*

for expensive accidents. Other businesses, such as restaurants and florists, are often denied coverage because their employees are seen to be at high risk for contracting AIDS. Doctors and lawyers often are refused coverage because insurers expect them to have higher than average claims rates.[5] This process affects many small businesses and makes insurance unattainable even for many who can afford it.

The Instability of The Small Group Market—A final problem small groups must face purchasing insurance is the instability of the small group market as a whole. According to the General Accounting Office, about 30 percent of insured firms leave their insurance companies each year.[6] Often businesses are forced to change carriers because they have experienced high health costs during the initial life of their policy and have found their premiums raised significantly when they try to renew. Other groups with high health costs during the initial term of their policy find that their carrier refuses to renew them at any price. Additionally, more and more insurers are finding the small group market to be less profitable than other markets and are getting out of it altogether. This instability not only raises the administrative cost component of small group insurance, but greatly increases the expense to small firms of administering their insurance benefits.

"Out of 12 companies we contacted recently for quotes, only one was willing to provide. It is frustrating to try to provide adequate coverage at reasonable cost when insurance companies do not want to service our type of industry and chronically ill employees and dependents."
—the personnel coordinator of an organization serving seniors in Arkansas

Survey Results

Surveys were sent to over 2500 non-profit organizations throughout the United States. Four hundred sixty-seven (467) responded. The charitable organizations that received the survey were affiliated with one of the following five national associations: the National Headstart Association, the National Association of Area Agencies on Aging, the National Association of Community Health Centers, the National Association of Church Personnel Administrators, and Independent Sector.

The delivery of education services was the most common mission of the respondents, with one-quarter listing it as their organization's work. Health care delivery, medical research and human services work were each provided by over 10 percent of the respondents. The missions of the remaining respondents were in the areas of the arts, the environment, religion, advocacy, international services and grantmaking.

Seventy percent of the respondents accepted private donations or grants. Over 85 percent had 501(c)(3) status under the Internal Revenue Code, and all are non-profit organizations.

In order to tabulate the data, the organizations were broken down by number of employees. The following categories were used: under 6, 6-15, 16-30, 31-50, 51-100 and over 100. As Table 1 shows, the single largest group of responding organizations was the 6-15

TABLE 1

Size of Charities Responding to Survey

	Total[a,b]	Under 6	6-15	16-30	31-50	51-100	Over 100
Number of Firms	467	49	95	91	57	72	90

[a] The individual entries do not add up to the total, as some respondents did not report group size.
[b] Totals will vary in subsequent tables, as not all respondents answered all survey questions.

TABLE 2

Charities That Offer Health Insurance for Dependents of Employees

	Size of Organization						
	Total[a]	Under 6	6-15	16-30	31-50	51-100	Over 100
Yes #	403	40	72	76	51	67	87
%	87	82	76	84	89	93	97
No #	62	9	23	14	6	5	3
%	13	18	24	16	11	7	3

[a] The individual entries in each row do not add up to the total, as some respondents did not report group size.

employees category. The category representing organizations with under six employees had the smallest number of respondents (49).

Insurance Coverage

All organizations responding to the survey provided health insurance benefits for their employees. On average, 87 percent extended the benefit to dependents. Large employers were more likely to provide dependent coverage than the smallest employers. As Table 2 indicates, almost all charitable organizations with over 100 employees offered dependent coverage, whereas 18 percent of the charities with less than six employees, and almost one-quarter of the charities with 6–15 employees, did not provide health coverage for dependents. The fact that all charitable organizations responding to the survey offered health insurance to their employees—and, in the majority of situations, to their dependents—is noteworthy. Charities that offer insurance for their employees were undoubtedly more willing to complete and return the survey. Nevertheless, these results also probably indicate that non-profit charitable organizations are more likely than other small businesses to offer health insurance benefits. This may be because charitable organizations feel that providing health insurance benefits is consistent with their mission.

Types of Plans Offered—As Table 3 indicates, indemnity plans were by far the most commonly offered insurance plan, with over three-quarters of the respondents providing this type of insurance. Managed care plans were offered by 39 percent of the organizations. Such plans were more common in the larger groups. One-tenth of the respondents self-insured yet, once again, this practice was more prevalent in the larger groups, with over a quarter of the charities with more than 100 employees self-insuring. A combination system, in which the employer self-insures but contracts with an insurance carrier to administer the plan, was used by 14 percent of the respondents—22 percent of those with 51 to 100 employees and 27 percent of those with over 100 employees.

Approximately half of the charitable organizations responding to the survey did not require any employee premium contributions for individual coverage. For those that did, Table 4 provides information on the amounts paid by employees. The average employee contribution for single coverage was $27 per month or 10 percent of the average individual premium in 1991. Employees in firms with fewer than six workers paid the most—$78 monthly. Employees of firms with between 16–30 workers paid the least, with an average monthly payment of $15.

Employee contributions for family coverage were more common, and employees paid much more for family coverage. Two-thirds (66%) of the charitable organizations required employees to pay part of the premium for family coverage. For these charities, the average monthly employee contribution was $152, or roughly 35% of the

TABLE 3

Types of Plans Offered

		Size of Organization[a]						
		Total[b]	Under 6	6-15	16-30	31-50	51-100	Over 100
Indemnity Plan	#	368	40	74	72	43	57	74
	%	79	82	78	79	75	79	82
Managed Care Plan	#	182	16	28	36	23	31	43
	%	39	33	29	40	40	43	48
Self-Insured	#	46	2	6	2	2	9	24
	%	10	4	6	2	4	13	27
Part Insurance/ Part Self-Insured	#	64	3	7	10	3	16	24
	%	14	6	7	11	5	22	27
None of The Above	#	12	--	1	5	1	3	1
	%	3		1	5	2	4	1

[a] Totals in all columns may exceed 100 percent, as many firms offered more than one plan.
[b] The individual entries in each row do not add up to the total, as some respondents did not report group size.

TABLE 4

Monthly Employee Contributions Toward Indemnity Premiums[a]

	Size of Organization						
	Total[a]	Under 6	6-15	16-30	31-50	51-100	Over 100
Single Coverage	$ 27	$ 78	$ 25	$ 15	$ 21	$ 26	$ 21
Family Coverage	$152	$145	$151	$151	$147	$192	$136

[a] The averages are for groups that required employee contributions. Close to half of all respondents did not require employee contributions toward premiums.

average family premium. Employees in firms with 51–100 workers paid the most, an average of $192 per month. Employees in firms with over 100 workers paid the least—$136 per month.

What Non-profit Charities Cover—The organizations surveyed offered coverage that is typical of most employer-sponsored health insurance coverage. Table 5a shows the various services offered. Hospital and surgical services were covered by 95 percent of the indemnity plans offered by respondents, and x-ray and laboratory services were covered by 94 percent. Physician office visits and inpatient and outpatient mental health were covered by 84 to 88 percent of the indemnity plans. As Table 5b indicates, over three-quarters of the respondents provided prescription drug coverage for their employees, either through an indemnity plan or separate policy. Three-fifths provided dental coverage and almost one-quarter offered vision coverage. These supplementary benefits were more common in the larger groups, but only 15 percent of the respondents did not offer any of these supplementary benefits.

Over one-third of the survey respondents reported some limitations on usage of benefits, such as inpatient mental health coverage limited to 30 days or coverage for only the first $1000 of dental expenses. Surprisingly, the policies provided through smaller charities had the fewest limits, whereas policies offered by half of the charities with over 100 employees limited benefits.

"We changed carriers and now only offer physician office visits, hospital, mental health and prescription drugs. It took seven months to find a company that could meet our expectations and dollar figure. Even after seven months, we had to cut out many benefits offered in 1988, 1989, and 1990. Our new policy is not one which endorses wellness."
—human services director of a 50-employee rural health organization in Virginia.

Discriminatory Rating Experiences

While the charitable organizations surveyed were able to provide health insurance for their employees, they were not immune to

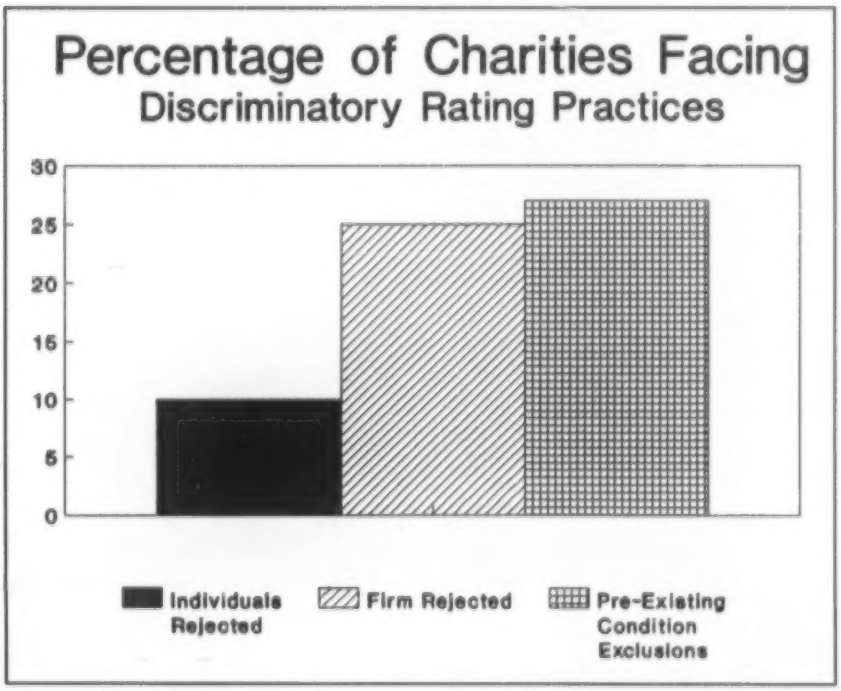

TABLE 5a

Benefits Covered Under Indemnity Plans

		Size of Organization						
		Total*	Under 6	6-15	16-30	31-50	51-100	Over 100
Hospital Services	#	349	37	69	68	40	56	73
	%	95	93	93	94	93	98	99
Surgical Services	#	349	37	69	68	40	56	73
	%	95	93	93	94	93	98	99
Physician Office Visits	#	311	30	65	61	34	52	64
	%	85	75	88	85	79	91	86
X-Ray and Laboratory Tests	#	347	36	68	68	40	56	73
	%	94	90	92	94	93	98	99
Inpatient Mental Health	#	323	33	62	65	39	51	68
	%	88	83	84	90	91	89	92
Outpatient Mental Health	#	308	30	58	59	36	53	67
	%	84	75	78	82	84	93	91
Other	#	113	13	26	17	15	13	26
	%	31	33	35	24	35	23	35
None of The Above	#	18	2	5	4	3	1	1
	%	5	5	7	6	7	2	1

* The individual entries in each row do not add up to the total, as some respondents did not report group size.

TABLE 5b

Benefits Covered Under Indemnity Plans or Through Separate Policies

		Size of Organization						
		Total*	Under 6	6-15	16-30	31-50	51-100	Over 100
Dental	#	279	28	56	48	36	43	62
	%	60	57	59	53	63	60	69
Prescription Drugs	#	358	34	65	70	44	59	77
	%	77	69	68	77	77	82	86
Vision	#	101	6	15	20	12	19	26
	%	22	12	16	22	21	26	29
None of The Above	#	72	11	16	14	7	10	10
	%	15	22	17	15	12	14	11

* The individual entries in each row do not add up to the total, as some respondents did not report group size.

discriminatory rating practices. These included exclusions of individuals due to their health histories; denials of coverage for preexisting conditions; and rejections by insurers. Charities of all sizes were affected by these practices.

Medical underwriting affected all of the businesses responding to the survey. As Table 6 shows, ten percent of the responding organizations had an employee excluded completely from coverage due to illness or physical condition. More than a quarter of the respondents had individuals denied coverage for pre-existing conditions. Excluding individuals from coverage occurred more frequently in charities with 50 or fewer employees. Excluding coverage for preexisting conditions was most common in the largest groups, but also affected about one-quarter of the smaller ones.

As Table 6 illustrates, over one-quarter of the respondents were rejected outright by at least one carrier. Common reasons for rejection were exclusion of the industry and past claims experience.

Insurers did not limit pre-existing condition exclusions to just the condition itself: *The insurer of an educational institution in Michigan would not cover psychiatric services for one year for an employee who had a hysterectomy.*

The Costs of Providing Care

The charitable organizations surveyed experienced substantial cost increases in the premiums for health care plans provided to their employees. From 1988 to 1991, the health insurance premiums paid by the charities surveyed increased by 84 percent on average. This rate of increase far exceeded that of other related costs. During the same period, the Consumer Price Index increased 15 percent and general health care spending increased 35 percent. Health insurance premiums in general increased 56 percent.[7]

These large premium increases affected both individual and family indemnity plans, as well as individual and family managed care plans

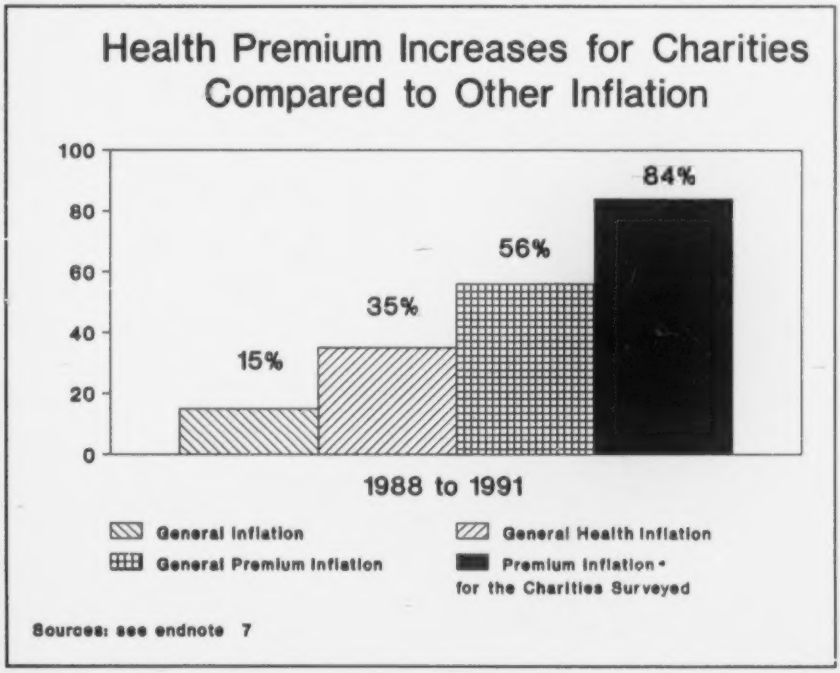

TABLE 6

Discriminatory Rating Practices

		Individuals excluded due to illness or physical condition		Individuals denied coverage for pre-existing conditions		Firm rejected by insurers	
		Yes	No	Yes	No	Yes	No
Total*	#	47	403	125	328	115	344
	%	10	86	27	70	25	74
Under 6	#	4	42	9	36	14	34
	%	8	86	18	73	29	69
6-15	#	15	77	20	73	20	73
	%	16	81	21	77	21	77
16-30	#	10	77	23	65	21	68
	%	11	85	25	71	23	75
31-50	#	9	45	14	41	19	37
	%	16	79	25	72	33	65
51-100	#	3	69	17	55	25	47
	%	4	96	24	76	35	65
Over 100	#	5	82	36	51	12	76
	%	6	91	40	57	13	84

* The individual entries in each column do not add up to the total, as some respondents did not report group size.

(see Table 7). The average premium increases for individual indemnity plans from 1988 to 1991 was 84 percent. Groups with 16-30 employees endured the stiffest increases for individual coverage—169 percent, or roughly twelve times greater than general inflation and almost five times greater than health inflation over the three years. Generally such stiff increases occur after several years of experience with the same insurer, or if a member of the group experiences high health bills.

Increases in the premiums for family indemnity plans were also substantial. Premiums over the three years of the survey almost doubled (91%) or increased at roughly six times the rate of general inflation and over two and one-half times the rate of health inflation. Surprisingly, large charities experienced the greatest cost increases, with organizations with over 100 employees experiencing average increases of 130 percent.

Charitable organizations offering managed care plans for both families and individuals were affected by large price increases that rivaled those in indemnity plans. The mean increases of 60 percent for individual plans and 96 percent for family plans far exceeded general inflation as well as health cost inflation. Very small charities fared even worse. Groups with fewer than six employees experienced health inflation rates of 126 percent for individuals and 118 percent for families. Conversely, large charities (with over 100 employees) experienced increases which averaged slightly higher than 50 percent.

"The cost of family coverage is now prohibitive for too many of our lower salaried employees and they are being forced to pursue alternative health care—public clinics—for their dependents."—the personnel director of a Washington, D.C. health center with over 100 employees

Cost Containment Efforts

In response to the spiraling increases in their premiums, most charitable organizations took steps to lower costs. As indicated by Table 8a, the most frequent step was the solicitation of bids from other insurers. Over 80 percent of the respondents solicited new bids.

Close to half (49%) of the charitable organizations increased out-of-pocket health costs for their employees through one or more of the

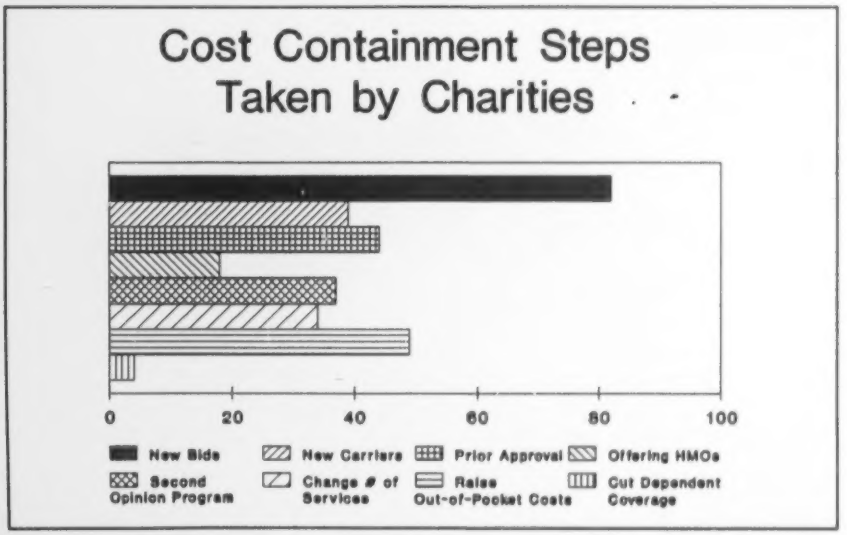

TABLE 7

Average Percent Increase in Premium Costs 1988-1991

		Size of Organization						
		Total*	Under 6	6-15	16-30	31-50	51-100	Over 100
INDEMNITY								
Individual	%	84	90	65	169	59	62	73
Family	%	91	73	76	77	90	65	130
MANAGED CARE								
Individual	%	60	126	67	56	67	53	52
Family	%	96	118	71	65	136	56	53

TABLE 8a

Steps Taken to Lower Health Care Costs

		Size of Organization						
		Total*	Under 6	6-15	16-30	31-50	51-100	Over 100
Sought Bids from Other Insurers	#	382	38	73	79	49	61	70
	%	82	78	77	87	86	85	78
Change Carriers	#	182	16	33	40	30	29	29
	%	39	33	35	44	53	40	32
Change Type or Number of Services	#	160	16	34	33	20	27	26
	%	34	33	36	36	35	38	29
Raise Out-of-Pocket Costs	#	230	22	41	46	25	41	47
	%	49	45	43	51	44	57	52
Cut Back on Dependent Coverage	#	21	2	5	5	3	4	2
	%	4	4	5	5	5	6	2
Initiated A Second Opinion Program	#	175	10	27	30	25	32	44
	%	37	20	28	33	44	44	49
Prior Approval	#	207	12	40	37	29	37	45
	%	44	24	42	41	51	51	50
Restrictions on Providers	#	85	7	13	13	11	19	19
	%	18	14	14	14	19	26	21
Offering HMOs	#	82	5	10	13	12	17	23
	%	18	10	11	14	21	24	26
Requiring HMOs	#	23	--	4	6	5	4	2
	%	5		4	7	9	6	2

* The individual entries in each row do not add up to the total, as some respondents did not report group size.

TABLE 8b

Steps Taken to Raise Out-of-Pocket Cost for Covered Individuals

		Size of Organization						
		Total*	Under 6	6-15	16-30	31-50	51-100	Over 100
Raised Contribution for Individuals	#	77	8	13	13	9	15	15
	%	16	16	14	14	16	21	17
Raised Contribution for Families	#	132	10	22	25	13	28	28
	%	28	20	23	27	23	39	31
Raised Deductible for Individuals	#	146	17	24	28	13	25	36
	%	31	35	25	31	23	35	40
Raised Deductible for Families	#	131	12	18	25	13	27	33
	%	28	24	19	27	23	38	37
Raised Co-Insurance Percentage	#	45	4	6	8	6	9	11
	%	10	8	6	9	11	13	12

* The individual entries in each row do not add up to the total, as some respondents did not report group size.

following methods: raising their premium contributions; increasing deductibles and/or co-payments; and limiting the number of services covered, thereby increasing the services employees must pay for directly (see Table 8b). The charities were more likely to raise premium contributions for family coverage than for employee coverage. Almost half the respondents established prior approval guidelines for specified medical procedures or hospitalization, and over one-third initiated second opinion programs.

"One employee only takes home $30 per pay check after the insurance costs for he and his spouse have been deducted."—a 25-member Indiana organization serving the elderly

Large charitable organizations were more likely to take these steps than small ones. Large groups tend to have benefit specialists who are knowledgeable about cost containment techniques. Smaller ones, however, rarely hire such specialists because the economies of scale would make such positions uneconomical. Additionally, small charities operate in a much more confining atmosphere when purchasing insurance. They have fewer choices of policies and do not have the buying power to negotiate cost containment programs.

Impact on Charities

Rising health insurance costs have had a significant budgetary impact on the charities surveyed. Between 1988 and 1991, health insurance premiums, as a percent of payroll, grew from a median of 6.6 percent to 8.4 percent—an increase of 27 percent. Over one-half of the respondents indicated that the rising costs of health insurance constrained employees' salaries. Additionally, roughly one-third of the respondents indicated that health costs hindered the opportunities for hiring additional staff to provide more services. This is consistent with the draconian effects of health care costs throughout the United States. As a 1991 Employee Benefits Research Institute study indicated, average wages only increased by one percent from 1970 to 1989 in constant 1989 dollars. Health benefits, however, increased by 163 percent.[8] Thus, employees have been absorbing health care's tremendous inflation at the expense of salary increases.

"Employees have opted to have insurance paid in lieu of increased salary. However, this year the board will need to reconsider this as insurance premiums have taken such drastic hikes that the clinic cannot continue to pay these high benefits for employees."—Utah medical center, 11 employees

Conclusion

Health care costs are eating up the charitable dollars that support the services provided by non-profit organizations in this country. These organizations would benefit greatly from the same cost containment reforms that many large corporations are advocating. Charitable organizations would also benefit from reforms that guarantee universal access to health insurance, as would large corporations, because such reforms would spread the costs of insurance more evenly across the population and eliminate cost-shifting.

A number of specific reforms in the small group market would eliminate many of the harmful insurance practices encountered by

charitable organizations. Reforms that require insurers to offer policies to all groups and to renew all policies would eliminate much of the instability in the market. Other reforms would greatly limit exclusions of pre-existing conditions and prohibit exclusions of individuals. Reforms that prohibit rating practices based on health history would stabilize premiums.

All of the above reforms must be part of the comprehensive health care reform our nation so desperately needs. Enacted in isolation, such small group reforms will not solve the common insurance problems described above. This is because health cost inflation is the engine driving insurers to engage in these objectionable practices. Only if small group insurance reforms are accompanied by cost containment and access reforms will the organizations surveyed have the resources to fulfill their charitable missions and meet the health care needs of the staff dedicated to fulfilling these missions.

Endnotes

1. The Pepper Commission, U.S. Bipartisan Commission on Comprehensive Health Care, *A Call for Action*, Final Report, September 1990, p. 25.

2. William J. Dennis, *Small Business Problems and Priorities*, The NFIB Foundation, 1992, p. 2.

3. Office of Advocacy, *Health Care Coverage and Costs in Small and Large Businesses*, Small Business Administration, April 1987.

4. Subcommittee on Health, Committee on Ways and Means, *Private Health Insurance: Options for Reform*, U.S. House of Representatives, September 1990, pp. 11-12.

5. *Ibid.*, p. 6, and Milt Freudenheim, "Health Insurers, to Reduce Losses, Blacklist Dozens of Occupations," *The New York Times*, February 5, 1990, pp. A1 and D5.

6. U.S. Government Accounting Office, *Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting*, May 1990, p. 30.

7. U.S. Department of Commerce, *1992 U.S. Industrial Outlook*, January 1992, pp. 7, 43-1, and Elizabeth W. Hoy *et al.*, "Change and Growth in Managed Care," *Health Affairs*, Winter 1991, Vol. 10, Number 4, p. 20.

8. Robert J. Blendon *et al.*, "The Future of Private Health Insurance," *Health Affairs*, Winter 1991, Vol. 10, Number 4, p. 173.

Appendix A

Families USA
Families United for Senior Action

National Survey On Health Insurance

Name of Organization _____

Address _____

Telephone Number _____

Name and Title (person filling out form) _____

NOTE: All responses to this questionnaire will be kept confidential. If you need more space to complete any answer or want to add comments, please feel free to use the space provided on the last page or add additional pages to the end of this form.

PLEASE RETURN THIS FORM REGARDLESS OF YOUR INSURANCE COVERAGE

1. a. Are you a non-profit organization? Yes☐ No☐

   b. **If no, stop here and return the questionnaire.**

   c. If yes, do you have 501(c)(3) status? Yes☐ No☐

2. a. How many full-time employees work for the organization?_____

   b. How many part-time employees work for the organization?_____

3. Through which organization did you receive this form?

   ☐ a. National Headstart Association
   ☐ b. National Association of Area Agencies on Aging
   ☐ c. National Association of Community Health Centers
   ☐ d. National Association of Church Personal Adiminstrators
   ☐ e. Independent Sector

4. If you are associated with the Independent Sector, what is your type of organization? (Pick only one)

   ☐ a. Arts, Cultural, Humanities
   ☐ b. Education/Instruction
   ☐ c. Environmental
   ☐ d. Animal Related
   ☐ e. Health, Mental Health and Medical Research
   ☐ f. Human Services, including Youth Development
   ☐ g. Religion
   ☐ h. Civil Rights, Social Action, Advocacy
   ☐ i. Recreation, Sports
   ☐ j. International
   ☐ k. Grantmaking Foundations
   ☐ l. Other

5. Do you receive any private contributions, such as individual donations or grants from private foundations? Yes☐ No☐

6. a. Do you offer health insurance for your employees? Yes☐ No☐

   b. If yes, go to question 7.

   c. If no, did you previously? Yes☐ No☐

   d. If no to (c), stop here and return the questionnaire.

   e. If yes to (c), when did you terminate?_____

   f. Why did you terminate?

   _____

   _____

   _____

IF YOU DO NOT PRESENTLY OFFER HEALTH INSURANCE, STOP HERE. PLEASE RETURN THE SURVEY TO US.

7. a. Do you offer health insurance for dependents? Yes☐ No☐

   b. If no, did you previously? Yes☐ No☐

   c. If you previously offered dependent coverage, when did you terminate? _____

   d. Why did you terminate dependent coverage?

   _____

   _____

   _____

   _____

8. Do you obtain insurance through an association or with a group of organizations similar to your own? Yes☐ No☐

9. If you offer any insurance, which of the following describes your plan: (check as many as apply)

   a. Do you provide an indemnity plan (through Blue Cross or a commercial insurer where people use any provider and pay fees for services)? Yes☐ No☐

   b. Do you provide a managed care plan (such as an HMO or PPO)? Yes☐ No☐

   c. Are you self insured (your organization takes the risk for the insurance claims of your employees) only? Yes☐ No☐

   d. Are you covered in part by an insurance company and in part self insured? Yes☐ No☐

10. a. How many full-time employees are covered by your plans? _____

    b. How many part-time employees are covered by your plans? _____

    c. (1) How many single plans do you provide? _____

       (2) How many family plans do you provide? _____

11. If you have an indemnity health plan, supply the following cost sharing information:

    a. How much of the monthly premium is paid for by employee:

       Single $_____ Family $_____

    b. Annual deductible:

       Single $_____ Family $_____

    c. Coinsurance (Percentage of doctor and other provider fees paid by employee – ex. 20%):

       Medical_____% Mental Health_____%

    d. Out of Pocket annual limit:

       None___ Single $_____ Family $_____

    e. Lifetime maximum dollar coverage amount:

       None___ Medical $_____ Mental Health $_____

    f. Annual maximum dollar coverage amount:

       None ___ Medical $_____ Mental Health $_____

12. If you currently have an indemnity health plan, which benefits are covered?

    g. Hospital services? Yes☐ No☐
    h. Surgical services? Yes☐ No☐
    i. Physician office visits? Yes☐ No☐
    j. X-ray and lab? Yes☐ No☐
    k. Inpatient mental health? Yes☐ No☐
    l. Outpatient mental health? Yes☐ No☐
    m. Other? (specify) Yes☐ No☐

    _____

    _____

13. Do you cover the following services either under the indemnity plan or through separate policies:

    a. Dental? Yes☐ No☐
    b. Prescription drugs? Yes☐ No☐
    c. Vision? Yes☐ No☐

14. a. Are there any limitations on the number of services covered? Yes☐ No☐

    b. If yes, what are the limits and on which services?

    _____

    _____

    _____

15. If you currently have a managed care plan, how much of the monthly premium is paid by the employee?

    Does Not Apply___ Single $_____ Family $_____

ANSWER QUESTIONS 16 THROUGH 22 FOR 1988 TO THE PRESENT

16. What were your average monthly premium costs for each individual employee and each family for the last few plan years? (A plan year begins on the date your insurance contract begins.)

Include both the employer and employee contribution.

a. For the plan year that began during 1991 (projected):

(1) for an individual:

Indemnity Plan	Managed Care Plan
$_____	$_____

(2) for a family:

Indemnity Plan	Managed Care Plan
$_____	$_____

b. For the plan year that began during 1990:

(1) for an individual:

Indemnity Plan	Managed Care Plan
$_____	$_____

(2) for a family:

Indemnity Plan	Managed Care Plan
$_____	$_____

c. For the plan year that began during 1989:

(1) for an individual:

Indemnity Plan	Managed Care Plan
$_____	$_____

(2) for a family:

Indemnity Plan	Managed Care Plan
$_____	$_____

d. For the plan year that began during 1988:

(1) for an individual:

Indemnity Plan	Managed Care Plan
$_____	$_____

(2) for a family:

Indemnity Plan	Managed Care Plan
$_____	$_____

17. What were your total annual aggregate health care costs (the employer's contribution only) including insurance premiums (for indemnity and managed care plans combined) and total administrative costs (for example, the cost of the contract to the company that handles your claims processing) incurred for self insurance?

a. For the plan year that began during 1991 (projected):

$_____

b. For the plan year that began during 1990:

$_____

c. For the plan year that began during 1989:

$_____

d. For the plan year that began during 1988:

$_____

18. What was your total annual payroll?

a. For the plan year that began during 1991 (projected):

$_____

b. For the plan year that began during 1990:

$_____

c. For the plan year that began during 1989:

$_____

d. For the plan year that began during 1988:

$_____

19. a. Have individuals been fully excluded from your plan because of illness or physical conditions?

Yes☐ No☐

b. If yes, for what illnesses or physical conditions?

_____

_____

_____

20. a. Have individuals been denied coverage for certain pre-existing health conditions but provided coverage for other conditions? Yes☐ No☐

b. If yes, for what conditions were individuals denied coverage and for what length of time?

_____

_____

_____

21. a. Has your firm been rejected by insurers? Yes☐ No☐

b. If yes, check one or more of the reasons provided for the rejection:

☐ a. health history
☐ b. financial instability
☐ c. past claims
☐ d. exclusion of your industry
☐ e. other

_____

_____

22. Have you taken any of the following steps to lower your firm's health care costs? Yes☐ No☐

If yes, answer a-g.

a. (1) Have you sought bids from other insurers? Yes☐ No☐

(2) If yes, did other insurers offer you coverage? Yes☐ No☐

b. (1) Did you change carriers? Yes☐ No☐

(2) If yes, when? _____

c. (1) Did you change the type or number of services covered? Yes☐ No☐

(2) If yes, what changes were made?

_____

_____

_____

_____

d. (1) Did you raise the out-of-pocket costs of the covered individuals? Yes☐ No☐

(2) If yes, which of the following changes did you make for any of your plans?

(a) Raise employee contribution toward premiums:

i. For individuals? Yes☐ No☐

ii. If yes, how much? $_____

iii. For families? Yes☐ No☐

iv. If yes, how much? $_____

(b) Raise deductibles:

i. For individuals? Yes☐ No☐

ii. If yes, how much? $_____

iii. For families? Yes☐ No☐

iv. If yes, how much? $_____

(c) Raise co-insurance percentage: Yes☐ No☐

i. If yes, how much on what services?

_____

_____

_____

(d) Were annual or lifetime maximums imposed or lowered on covered expenses? Yes☐ No☐

i. If yes, what changes were made?

_____

_____

_____

e. (1) Did you cut back on dependents' coverage? Yes☐ No☐

(2) If yes, how?

f. Did you initiate use of other cost containment mechanisms? Yes☐ No☐

If yes, which of the following:

(1) Second opinion program? Yes☐ No☐
(Before services are rendered, a second doctor must confirm services are required.)

(2) Prior approval? Yes☐ No☐
(Insurer must approve services before they are rendered.)

(3) Restrictions on which providers can be used (e.g., preferred provider organizations where employee must pay higher cost sharing to providers that are not designated)? Yes☐ No☐

(4) Offering HMOs? Yes☐ No☐

(5) Requiring HMOs for all employees? Yes☐ No☐

(6) Other

g. Other steps taken not previously mentioned?

23. How is the rise of health care costs affecting your operations? (Check as many as apply)

☐ a. constrained salaries for current employees
☐ b. constrained expansion of staff
☐ c. reduced services provided. How?

☐ d. reduced other expenditures? How?

☐ e. other? (explain)

24. Is there anything else you want to tell us about your experience with health care coverage?

Continuation of Comments

(Please indicate the number of which question your comments address.
Additional space is provided on the reverse side of this page.)

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